Employer verification form

TO BE COMPLETED BY THE SAIF EMPLOYEE'S DEPENDENT (spouse / domestic partner)

I authorize my employer to release the information below regarding my access to health insurance.

SAIF employee's name (print) _____

Name of SAIF employee's dependent (print) _____

Signature of dependent _____ Date _____

☐ Not applicable because: _____

TO BE COMPLETED BY THE ABOVE LISTED DEPENDENT'S EMPLOYER

Dear employer,

Please assist us in reviewing your employee's access to insurance coverage. Please check only one of the boxes below:

☐ We do not offer group medical coverage to our employees, OR we offer group medical coverage to our employees but this employee is not eligible because:

_____

☐ We offer group medical coverage to our employees and this employee is enrolled.

☐ We offer group medical coverage to our employees and this employee declined coverage.

Employer representative signature _____ Date _____

Representative name (print) _____ Title _____

Employer name _____ Phone _____

Address _____ City _____ State ___ Zip _____

Questions? Contact benefits@saif.com